Case 2:06-cv-00573-WC Filed 09/08/2006 Document 8-3 Page 1 of 52

PRISON I ALTH SERVICES: AUTHOR. ZATION LETTER

		O1 (<u>1</u>	
Patient Name:	Martin, Marlon	T	
Service Authorized:	Office Visits: Op Orthopedics Referral	Inmate Number:	225145MA
Efforti	Office visits. Op Orthopedics Referral	Effective Dates:	07/22/2005 to 09/22/2005
Pernoncial E	Visits authorized for 60 days from effective date.	Visits Authorized:	 _
	Staton Correctional Facility	Contact Name:	
Authorization Number:	15266125		
Note to Provider of Servi	Ces:	Telephone Number:	(334)395-5973 Ext 14
Medicaro/Modical	- 		

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services P.O. Box 967 Brentwood, TN 37024-0967

> The consulting physician should complete this section. The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

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ent of possible follow-up appointm	ents. ***
Date	
240	Time
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Date	Time
	ent of possible follow-up appointm

Case 2000 100 PART OF THE CASE PROPERTY OF SELECTION OF S

Form must be Complete and Legible. You must Type or Print

Please send thi on with the Authorization Letter to the service provider at the time of the Appointment DEMOGRAPHICS Site Name & Number: Patient Name: (Last, First,) Staton 843 Site Phone# (334) 567-1548 Site Fax # Inmate # (334) 567-1538 SS Number Will there be a charge? DE YES 1 No Strate | Female PHS ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans.) Responsible party: Auto Ins. Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services): CLINICAL DATA Requesting Provider: Physician Dental Dental history of illness/injury/sypmtoms with Date of Onset: nnee pain trecurrent sility Medical Director Signature and Date: Service meets criteria for "approval via protocol" Place a check mark (<) in the Service Type requested (one only) and complete additional applicable fields. Office Visit (OV) Scheduled Admission (SA) X-ray (XR) Outpatient Surgery (OS) Dialysis (DA) Routine Urgent Estimated Date of Service (mm/dd/yy) (This starts the approval window for the "open authorization period") Radiation therapy Multiple Visits/Treatments: -Chemotherapy-Number of Visits/Treatments: Other: response (including medications): Specialist referred to: Type of Consultation, Treatment: Procedure or Surgery Diagnosis: ICD-9 code: You must include copies of pertinent reports such as lab results, ray interpretations and specialty consult reports with this form. ***For security and safety, please do not inform patient of possible follow-up appointments*** Pertinent Documents have been attached and faxed. UM DETERMINATION: Offsite Service Recommended and Authorized Alternative Treatment Plan (explain here): More Information Requested: (See Attached) Date resubmitted: Resubmitted with requested information. Regional Medical Director Signature, printed name and date required; Do not write below this line. For Case Manager and Corporate Data Entry ONLY. Cert Type: Med Class: CPT code: UR Auth #: 15253824 U5a - UM Reterral review form

PRISON I LTH SERVICES: AUTHORL . TION LETTER

_			
Patient Name:	Martin, Marlon	Inmate Number:	225145344
Service Authorized:	Office Visits: Op Surgical Followup Referral	Transci.	223143WIA
		Effective Dates:	04/07/2005
Effective:	Visits authorized for 60 days from effective date.		
Responsible Facility	Staton Correctional Facility	Visits Authorized:	1
	·	Contact Name:	Michelle Pope
Authorization Number:	14881640		
Note to Drawid		Telephone Number:	(334)395-5973 Ext 14

Note to Provider of Services:

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)

Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the

- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services P.O. Box 967 Brentwood, TN 37024-0967

> The consulting physician should complete this section. The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility

NOTE: THE PERSON OF THE PERSON	
Clinical Summary or Attache	ed Report
3/p (P kno Al remmeter 9/15/2004 Re	in 2/2005 - Still pain-
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To 0-120 px- Phaler. @ andrin leftet	al just line - of in the
J. ? mensu ta	J Cast Mary.
Cat laving - MRI (R Kne and	pr p jam
*** For security and safety, please do not inform patient o	f possible follow-up appointments. ***
Signature of Consulting Physician:	Date Time
Reviewed and Signed By Medical Director:	Date Time H-27-05 Helry Date Gime

Sanders M. Benkwith, M.D. James R. Glassner, M.D. Tom Lyle Mitchell, Ir., M.D. John L. Swan, M.D. Name:	Work In.
Acct of	Int/Short Exam
CC/HPI	Date: 400 Age: M F
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QUAX TANA	Sys. Meds
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Letter to:	MA

MCD .

Over for Notes

_MD/OD

EYE EXAMINATION SHEET

TO: (Service Physician)	FROM: (Requesting Ward.Med. Fac. Phys.)	Date of Request:
Reason For Request: (Complaints and Finding)	Taton	4/22/05
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Past History		
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F-65 Rev. (1-95)	Varion	1 2205145

UTILIZATION ANAGEMENT REFERRAL R must be Complete and Legible. You must Type or From Please send this form with the Authorization Letter to the service provider at the time

W FORM

	DEMOGRAPHICS	
Site Name & Number: Patient Name: (L		
Staton 843	1. Marlon 321/05	
Site Phone # Alias: (Last, Firs	t,y Date of Birth: (mm/dd/yy)	
(334) 567-1548 Site Fax #	12,17,70	
Site Fax # Inmate #	PHS Custody Date: (mm/dd/yy)	
(334) 567-1538 SS Number	09,18,02	
Will there be a charge? Sex	Potential Release Date: (mm/dd/yy) 7 8-3 6 1 0 1 2 12 0 10 Φ	
Responsible party: PHS Health Ins.(Exc	ludes Medicare/Medicaid Managed Care alternative plans)	
☐ Auto Ins. ☐ Other, be speci	fic (Excludes Medicare, Medicaid and Veterans Administration Services):	
Bourseting Desirit.	CLINICAL DATA	
Requesting Provider: Physician NP, PA	Dental	
MEXANTHUM	History of illness/injury/sypmtoms with <u>Date of Onset</u> :	
Facility Medical Director Signature and Date:	- SPERIAL report	
	Seen By Dr. Chama 3/18/55	
Service meets criteria for "approval via protocol"	Seen By Dr. Clauma 3/18/55 who requests Truin	
Place a check mark (✓) in the Service Type requested (one on complete additional applicable fields.	BINCOWS	
Office Visit (OV) X-ray (XR) Scheduled Admission	Results of a complaint directed physical examination:	
Outpatient Surgery (OS) Dialysis (DA)		
Routine Urgent		
Estimated Date of Service (mm/dd/yy)		
(This starts the approval window for the "open authorization per	iod")	
Multiple Visits/Treatments: Radiation therapy		
Number of Visits/Treatments: Other:		
Specialist referred to:	Previous treatment and response (including medications):	
Type of Concultation, Treatment, Procedure or Surgery:		
April 27,05 @ 230	' []	
Diagnosis: AC repow		
ICD-9 code: You must include copies of pertinent reports such as lab resul		
ray interpretations and specialty consult reports with this form	***For security and safety, please do not inform patient of	
Pertinent Documents have been attached and faxed. UM DETERMINATION: Offsite Senice Becc	possible follow-up appointments***	
El Orisic Service Nect	ommended and Authorized	
☐ Alternative Treatment Plan (explain here): ☐ More Information Requested: (See Attached)	FAXED	
Date resubmitted:		
Resubmitted with requested information.	4/6/of (4)	
Regional Medical Director Signature, printed name and date required:		
Do not write halaw to a	[and Const. Married 177]	
	For Case Manager and Corporate Data Entry ONLY.	
Cert Type: Med Class: CPT code:	ÜR Auth #:	

PRISON HEA TH SERVICES: AUTHORIZA? IN LETTER

Patient Name:	Martin, Marlon	Inmate Number:	225145MA
Service Authorized:	Office Visits: Op Surgical Followup Referral	Effective Dates:	04/07/2005
Effective:	Visits authorized for 60 days from effective date.	Visits Authorized:	1
Responsible Facility:	Staton Correctional Facility	Contact Name:	Michelle Pope
Authorization Number:	14881640	Telephone Number:	(334)395-5973 Ext 14

Note to Provider of Services:

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
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- Payment will not be processed until we receive a clinical summary.

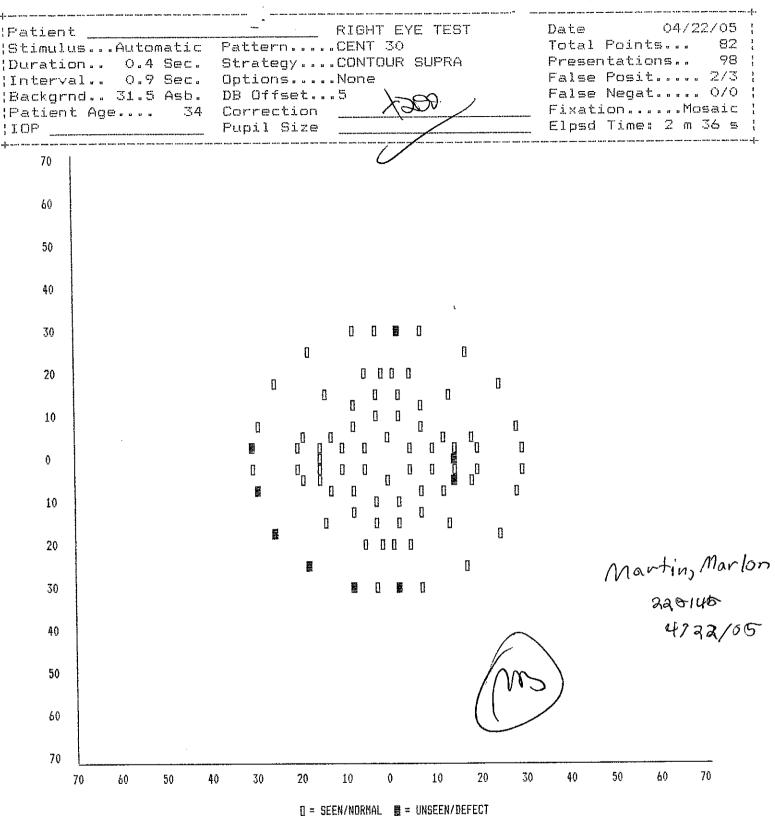
For Payment Please Submit Claims To:

Prison Health Services P.O. Box 967 Brentwood, TN 37024-0967

The consulting physician should complete this section.

The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

Clinical Summ	ary or Attached Report	
	4	
		<u></u>
*** For security and safety, please do not in	nform patient of possible follow-up appoin	tments. ***
Signature of Consulting Physician:	Date	Time
Reviewed and Signed By		
Medical Director:	Date	Time



Case 2 PR 1500573 WC T Document 8-3 Filed 09/08/2006 Page 9 of 52 SERVICES: AUTHORIZ TIO

	AUT	HORIL TIO	ETTER
Patient Name:	Martin, Marlon	· · · · · · · · · · · · · · · · · · ·	
Service Authorized:	Office Visits: Outpatient Optometry Referral	Inmate Number:	225145MA
	Visits authorized for co. 1	Effective Dates:	02/03/2005 to 09/03/2005
	Staton Correctional Facility	Visits Authorized:	1
Authorization Number:	14660018	Contact Name:	Michelle Pope
Note to Provider of Service Medicare/Medicaid do no		Telephone Number:	
not applicable	" cover any health some		

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
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> The consulting physician should complete this section. The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

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S/P 9/04 - ALL recombing - HZs been on, which he synd - from his Chin 3-> who ay Les Word held - No fresh - Row - 0' - 120' flor	
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*** For security and safety, please do not inform patient of possible follow-up appointments. ***	
appointments. ***	
Signature of Consulting Physician: 1 will 3/18/05	
Reviewed and Signed By	-
iviedical Director:	\dashv
Date Time	-
42125	

UTILIZATION N NAGEMENT REFERRAL PTVIE FORM Imst be Complete and Legible. You must Type o nt Please send this form with the Authorization Letter to the service provider at the time of the Appointment

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Site Name & Name		SRAPHICS	
Site Name & Number:	Patient Name: (Last, First		Date: (mm/dd/yy)
Staton 843	MARTIN	MARLON	03,16,05
Site Phone #	Alias: (Last, First,)		Date of Birth: (mm/dd/yy)
(334) 567-1548			
Site Fax #	Inmate #		PHS Custody Date: (mm/dd/yy)
(334) 567-1538	2251	45	
Will there be a charge? Sex	SS Number		Potential Release Date: (mm/dd/yy)
Will there be a charge? Sex Yes No Male Female			
Responsible party:	Health Ins.(Excludes Medic	are/Medicaid Managed Care alternati s Medicare, Medicaid and Veterans A	ive plans) Administration Services):
		AL DATA	
Requesting Provider: Physician	☐ NP, PA ☐ Dental		
WINFRO WI	illans	History of illness/injury/s	sypmtoms with <u>Date of Onset</u> :
Facility Medical Director Signature and Date	e: /	5/P AC	CL Rapair
of there		W/ Rs.	injury, Fall 22 mgs
Service meets criteria for "approval via protocol"			(1) on a , , , , , , , , , , , , , , , , , ,
Place a check mark (✓) in the Service Typ complete additional applic	e requested (one only) and able fields.		
Office Visit (OV)	Scheduled Admission (SA)	Results of a complaint d	irected physical examination:
Díalysis (DA)		-	
Routine	Urgent	Joint 11	· ROM comitso
Estimated Date of Service (mm/dd/yy)	1 1	EFFUSION	· ROM imitso
(This starts the approval window for the "o	pen authorization period")	to 20	FURIN
Multiple Visits/Treatments:	Radiation therapy		1
N	Chemotherapy Other:		
Specialist referred to: Dr. Chin	<u>"</u>	Previous treatment and	response (including medications):
Type of Consultation, Treatment, Procedur	e or Surgery:	ACC RIG	DAIR PROFILES.
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I wither I	du	Cruter	12.
6134 Windon Blowd Bld XV	ng .		
Diagnosis: KNEE 191N	3/10/03/3/5/		
You must include copies of pertinent repor	ts such as lab results, x-		
ray interpretations and specialty consult re Pertinent Documents have been attact	l l		safety, please do not inform patient of e foliow-up appointments***
UM DETERMINATION:	Offsite Service Recommended		
Alternative Treatment Plan (explain here):	Crisite Service Recommended	and Authorized	
☐ More Information Requested: (See Attached)			
- Hore Milotinadon Requested: (See Attached)	Date resubmitted:		
Resubmitted with requested information.			
Regional Medical Director Signature, printed name and date required:			
			/
Do not v	vrite below this line. For Case	Manager and Corporate Data I	Entry ONLY.
Cert Type; Med Class:	CPT code:		UR Auth #:
U5a - UM Referral review form	<u> </u>		

PRISON HEALT SERVICES: AUTHORIZATIO LETTER

Page 11 of 52

Patient Name:	Martin, Marlon	Inmate Number:	225145MA
Service Authorized:	Office Visits: Outpatient Optometry Referral	Effective Dates:	02/03/2005 to 09/03/2005
Effective:	Visits authorized for 60 days from effective date.	Visits Authorized:	1
Responsible Facility:	Staton Correctional Facility	Contact Name:	Michelle Pope
Authorization Number:	14660018	Telephone Number:	(334)395-5973 Ext 14

Note to Provider of Services:

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For Payment Please Submit Claims To:

Prison Health Services P.O. Box 967 Brentwood, TN 37024-0967

•	returned with an officer to the correctional facility.				
Clinical Sumn	nary or Attached Report				
· · · · · · · · · · · · · · · · · · ·					
*** For security and safety, please do not	inform patient of possible follow-up appoir	ntments. ***			
Signature of Consulting Physician:	Date	Time			
Reviewed and Signed By		m'			
Medical Director:	Date	Time			

The consulting physician should complete this section.

EYE EXAMINATION SHEET

TO: (Service Physician)	FROM: (Requesting Ward, Med. Fac. Phys.)	Date of Request:
DR BRADfond		1/28/05
Reason For Request: (Complaints and Finding)		- /
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00.20/15	5 9 CASSGS OU 20/20	
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Signature		
	Type of Consult ☐ Emergency ☐	Routine CAGO
	CONSULTATION REPORT	
OD	ОРНТН:	
Subjective: OS		·
New Rx: OD Seg. Ht.	Ext: Date Dispensed & Initials:	
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Patients Last Name	Circle Battle	
MARHN, MARLON	First Middle Age R/S	1DNo.
F-65 Rev. (1-95)		125145
	12/17/70	

Case 2:06-cv-00573-WC	Document 8-3	
Please send this form with the Author	rization Letter to the s DEMOGRAPHI	ervice provider at the time of the Appointment
Site Name & Number; P(Na	ime: (Last, First)	Date: /dd/yy)
Staton 843 Staton Mr	KTIN MAN	
Site Phone # Alias: (Li	ast, First,)	Date of Birth: (mm/dd/yy)
(334) 567 - 1548		1/2,/7,70
Site Fax # Inmate #		PHS Custody Date: (mm/dd/yy)
(334) 567 - 1538	25145	12,10,02
Will there be a charge? Sex SS Num XYes No Make Female		Potential Release Date: (mm/dd/yy) [1 2, 20, 06
Responsible party: Pris He	salth lins.(Excludes Medicare/N	fedicald Managed Care atternative plans)
AAto Inc. Oo	ther, be specific (Excludes Mea	
Parasting Prodder	CLINICAL	DATA
Requesting Provider: Defysician NP.	PA Dental	History of Managhatra and All Date of Orest
Winfred WilliAnd		History of Illiness/injury/sypmtoms with <u>Date of Onset</u> :
Tacility Medical Process Signature and Date:		1/// 1000 (1)
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Service meets tarbets for approval 1ts protocol	بديني المحار الراج الربعين لمدخ الراج	unable to se print-Lg
Place a check mark (1) in the Service Type req and complete additional applicable		on Eye chant
	theduled Admission (SA)	Results of a complaint directed physical examination:
Companient Surgery (OS) Tradysts (ON)		(a) 30/15
∐ Routine ☐ Us	gent	(R) 20/15
Estimated Date of Service (mm/dd/yy)	JJ	G. 20/2004_ wrable to Road
(This starts the approval window for the "open a		
in an a control of the control of th	liation therapy emotherapy	
. Number of Visits/Treatments: Ode	• •	
Specialist referred to: Dr. Brixofor	- 0	Previous treatment and response (including medications):
Type of Consultation, Treatment, Procedure of		Conservation.
upthornology Eval.	n saigery;	
oppromisery eval.		11
You must include copies of pertinent reports	s such as lab results.	
x-ray Interpretations and specialty consult r		***For security and safety, please do not inform patient of possible follow-up appointments***
UM DETERMINATION:	Offsite Service Recommer	nded and Authorized
Atternative Treatment Plan (explain here):		
☐ More Information Requested: (See Attached)	Delegant William	THE SKIP IN
. Resubmitted with requested information.	Date resubmitted:] Piliatos W
Regional Medical Director Signature,		
printed name and date required:		imm(ddfrr)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Med Class.

UR Auth#:

Cerl Type:



PROGRESS NOTES

Date/Time	Inmate's Name: Martin, Maylon #205/45 D.O.B.: 12/17/70
13/05	5/p @ Knu tel reconstruct 9/15/04
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UTILIZATION M. AGEMENT REFERRAL REVI. V FORM Form must be Complete and Legible. You must Type or Print Please send this form with the Authorization Letter to the service provider at the time of the Appointment

	DEMOGR	APHICS	- and an array position and
Site Name & Number:	Patient Name: (Last, First,)		Date: (mm/dd/yy)
Staton 843	Martin,	Marlon	10,21,04
Site Phone #	Alias: (Last, First,)		Date of Birth: (mm/dd/yy)
(334) 567 - 1548			12,17,70
Site Fax #	inmate #		PHS Custody Date: (mm/dd/yy)
(334) 567 - 1538	225/45		12,10,02
Will there be a charge? Sex	SS Number		Potential Release Date: (mm/dd/yy)
Yes No Mate Female	041-78-	3610	12,20,06
Responsible party: Auto Ins.	Health Ins. (Excludes Medican Other, be specific (Excludes N	e/Medicald Managed Care atte Medicare and Medicald):	mative plans)
	CLINICA		
Requesting Provider: Physician	□ NP, PA □ Dental		
WINFRED D. WE	luans	History of Illness/inj	ury/sypmtoms with <u>Date of Onset</u> :
Facility Medical Director Signature and Date		2/2/21	
Shight a shill	7	1 3/ (K)	tence ACL reconstructions by per Dr. Chung.
Service meets officeria for "approval via protocol"		on 9/15/	by ber M. Chund.
Place a check mark () in the Service Type<br and complete additional applied	pe requested (one only) cable fields.		, , , ,
Office Visit (OV)	Scheduled Admission (SA)	Results of a compla	int directed physical examination:
Outpatient Surgery (OS) Dialysis (DA)	,	00	00011
X) Routine [Urgent	0-	int directed physical examination: The flowing per h, lung,
Estimated Date of Service (mm/dd/yy)		\mathcal{L}	lund
(This starts the approval window for the "op-			
Multiple Visits/Treatments:	Radiation therapy Chemotherapy		V
A1	Other:	Previous treatment	and response (including medications):
Specialist referred to:			and response (meaning meancations).
Type of Consultation, Treatment, Procedus Follow-up Ortho Take 130000	or surgery;	,	
Take ?	Cray .		
1130000	m 4>		,
You must include copies of pertinent report	rts such as lab results.	-	
x-ray Interpretations and specialty consult	reports with this form.		and safety, please do not inform patient of
Pertinent Documents have been attach	ed and faxed.	poss	sible follow-up appointments***
UM DETERMINATION:	Offsite Service Recommended	and Authorized	
Alternative Treatment Plan (explain here):			D D D
More Information Requested: (See Attached)	Date resubmitted:		(28)
Resubmitted with requested information.			
Regional Medical Director Signature, printed name and date required:			1 1
Do not write below this line. For Case Manager and Corporate Data Entry ONLY.			
Cert Type:	Med Class:		UR Auth#: :) (
		·	14336673

PRISON HEAL A SERVICES: AUTHORIZAT*ON LETTER

Patient Name:	Martin, Marlon	Inmate Number:	225145MA
Service Authorized:	Office Visits: Op Surgical Followup Referral	Effective Dates:	09/22/2004
Effective:	Visits authorized for 60 days from effective date.	Visits Authorized:	1
Responsible Facility:	Staton Correctional Facility	Contact Name:	Michelle Pope
Authorization Number:	14214370	Telephone Number:	(334)395-5973 Ext 14

Note to Provider of Services:

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the
 referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of
 Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions
 under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not
 apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967

Brentwood, TN 37024-0967

The consulting physician should complete this section.

The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

Clinical Summary:01 Attac	hed Report	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1
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	101,5/24	
Signature of Consulting Physician:	Date T	ime
Reviewed and Signed By	10/18/04 A. M. Elan	2
Medical Director:	1 / 1 = -	ime

UTILIZATION NAGEMENT REFERRAL RE' TW FORM For just be Complete and Legible. You must Type or Print. Please send this form with the Authorization Letter to the service provider at the time of the Appointment.

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	COM TAINE. (LASE, FIRSE)		Date: (mm/dd/yy)
Staton 843	1) Jarlin m.	arlon	09,20,04
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(334) 567 - 1548		İ	18,17,70
Site Fax #	ımate #		PILS Contact Date of the C
(334) 567 - 1538	_		PHS Custody Date: (mm/dd/yy)
(004) 001 = 1000	285145		12110102
	S Number		Potential Release Date: (mm/dd/yy)
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	Chemotherapy Other:		
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Dr. I hung			
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x-ray interpretations and specialty consult	- i	***For security	and safety, please do not inform patient of
Pertinent Documents have been attach			sible follow-up appointments***
UM DETERMINATION:	Offsite Service Recommended	and Authorized	:
Alternative Treatment Plan (explain here):			
☐ More Information Requested: (See Attached)			
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Resubmitted with requested information.			
Regional Medical Director Signature, printed name and date required:			
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PRISON HEAL A SERVICES: AUTHORIZAT ON LETTER 19 of 52 Case 2:06-cv-00573-WC

PRIS	ON HEAL A SERVICES		
		Inmate Number:	225145MA
Patient Name:	Martin, Marlon	Effective Dates:	09/22/2004
Service Authorized:	Office Visits: Op Surgical Followup Referral	Visits Authorized:	1
Effective:	Visits authorized for 60 days from effective		Michelle Pope
Responsible Facility:	Staton Correctional Facility	Telephone Number	: (334)395-5973 Ext 14
Authorization Number:	14214370		n certain circumstances

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances Note to Provider of Services:
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services P.O. Box 967

Health Services		
The consulting physician sh The completed form will be seal	ould complete this section. ed in the attached envelope and o the correctional facility.	
returned	or Attached Report	
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T mod in	form patient of possible follow-up appointments. **	*
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	Date	1
Signature of Consulting Physician:		
	Date	
Reviewed and Signed By	Dut	
Medical Director:		

UTILIZATION (ON NAGEMENT REFERRAL REVHOW FORM) Form must be Complete and Legible. You must Type or Print Please send this form with the Authorization Letter to the service provider at the time of the Appointment

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Site Phone # Ali	as: (Last, First,)		Date of Birth: (mm/dd/yy)
(334) 567 - 1548			171110
Site Fax # In	nate #		PHS Custody Date: (mm/dd/yy)
(334) 567 - 1538	225145		12,10,02
	Number		Potential Release Date: (mm/dd/yy)
Will there be a charge? Sex	<u> </u>	10 0	12/20/06-cvs
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Responsible party. Auto Ins.	Other, be specific (Excludes M		
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Service meets criteria for "approval via protocol"			
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	Radiation therapy		
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x-ray interpretations and specialty consult Pertinent Documents have been attact	•	po:	ssible follow-up appointments***
UM DETERMINATION:	Offsite Service Recommender	d and Authorized	
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More Information Requested: (See Attached)			4 4 (1)
	Date resubmitted:	7	
Resubmitted with requested information. Regional Medical Director Signature,	<u> </u>	-	
printed name and date required:			/ / (mm/dd
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PRISON HEALTH SERVICES: AUTHORI

	T		
Patient Name	Martin, Marlon	Inmate Number:	225145MA
Service Authorized:	Office Visits: Op Surgical Followup Referral	Effective Dates:	
	Visits authorized for 60 days from effective date.	Visits Authorized:	
Responsible Facility:	Staton Correctional Facility	Contact Name:	
Authorization Number:	14004434	Telephone Number:	
Note to Provider of Co-	*	zasphone Humber:	(334)393-39/3 EXt 14

Provider of Services:

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances
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- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services P.O. Box 967 Brentwood, TN 37024-0967

> The consulting physician should complete this section. The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility

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		DR JM LHUNG
		Page 1 of 2
		1) Operative permit for Rolf Kale on Murry, white exhibit Light Month Market
		with puteller trader graft
		LAB: check appropriate diagnosis CBC: Pre op patient [V72 83] Abdominal pain Long term use of medications Other Fever
		B TYPE & SCREEN
		C CHEM 7: Edema Hypertensive disease Long term use of medications Diabetic Nephropathology Dizziness Other
		Cirrhosis hepatitis Known or suspected coagulation abnormality Anticoagulant therapy Hemorrhage or anemia Pulmonary congestion Other Cirrhosis hepatitis CHF Cardiac dysrhythmia Dysfunctional uterine bleed Menorrhagia
		Patients taking Digoxin Tegretol Theophylline Dilantin Depakor Phenobarb Other
		F URINE PREGNANCY On all menstruating females
		G UA: Diabetic Renal glycosuria Dehydration Stress incontinence Fever Dysuria Abdominal & pelvic pair Long term use medication
		H ADDITIONAL LAB TESTS:

Case 2:06-cv-00573-WC Document 8-3 Filed 09/08/2006 Page 24 of 52 Facility Name: | Month/Year of Charting: 6/06 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |

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Case 2:06-cv-00573-WC Document 8-3 Filed 09/08/2006 Page 25 of 52 Staton | Month/Year of Charling: 5 / 06 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | Facility Name: Flexeril 10mg + PO Tid X 2 days Prescriber: RX #: Hour 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 Robaxin 500mg PO BID x 10days $\frac{\dot{\sigma}}{\rho}$ Have no Start Date: Prescriber: Stop Date: RX #: 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 1 2 3 Hour Start Date: Prescriber: Stop Date: Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 3 Start Date: Prescriber: Stop Date: RX #: Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 3 Start Date: Prescriber: Stop Date: RX #: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 3 Start Date Prescriber: Stop Date: Nurse's Signature Initial Documentation Codes Diagnosis 1. Discontinued Order 2. Refused UKA Allergies 3. Patient out of facility 4. Charted in Error 5. Lock Down Housing Unit: Self Administered 225140 Patient ID Number: 7. Medication out of Stock Patient Name: 8. Medication Held 9. No Show

Marlon

Date of Birth.

10. Other

12/17/20

Case 2:06-cv-00573-WC Document 8-3 Filed 09/08/2006 Page 26 of 52 Facility Name: Month/Year of Charting: 14 13 14 15 16 17 18 22 23 24 25 26 27 28 29 30 31 Start Date: Prescriber Hour 7 8 9 10 11 12 13 14 15 16 17 18 Nopresyn 375mg
PO TID × 15.do 1210 Start Date: Prescriber: Stop Date: 21/2/06 RX #: Hour 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 Start Date: Prescriber: Stop Date: RX #: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 Hour Start Date: Prescriber: Stop Date: RX #: Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 Start Date: Prescriber: RX #: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 Hour Start Date: Prescriber: Stop Date: RX#: Diagnosis Initial Documentation Codes Discontinued Order Allergies 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down Housing Unit: 6. Self Administered Patient ID Number: Medication out of Stock Patient Name: 8. Medication Held Marlon 9. No Show Date of Birth: 10. Other

Case <u>2</u>:06-cv-00573-WC Document 8-3 Filed 09/08/2006 Page 27 of 52 Facility Name: Staton Correctional Facility | Month/Year of Charting: 01/06 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 Hour Naprosyn 375MG Tab 57.00 6A 901 Take 1 tablet(s) by mouth Three Times Daily Start Date: 12-20-2005 Prescriber: Peasant, John Stop Date: 01-07-2006 RX#: 250995466 Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 Start Date: Prescriber: Stop Date: RX #: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 Hour Start Date: Prescriber: Stop Date: RX #: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 Hour Start Date: Prescriber: Stop Date: RX #: 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 Hour 1 2 3 4 5 6 7 Start Date: Prescriber: Stop Date: RX #: Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 Start Date Prescriber: Stop Date: RX#: Diagnosis Nurse's Signature Initial s Signature אַנוּינוּע 's Documentation Codes 1. Discontinued Order Allergies 2. Refused 3. Patient out of facility 4. Charted in Error Housing Unit: Population 5. Lock Down 6. Self Administered Patient ID Number: 225140 Patient Name: 7. Medication out of Stock 8. Medication Held

Martin, Marlon

Date of Birth:

9. No Show 10. Other

Filed 09/08/2006 Page 28 of 52 Facility Name: Month/Year of Charting: 12 13 14 15 16 17 18 23 24 25 26 27 28 29 30 31 Start Date: Prescriber: Stop Date: 7 106 RX#: Hour 1 2 3 4 5 6 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 Start Date: Prescriber: Stop Date: RX #: Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 Start Date: Prescriber: Stop Date: Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 Start Date: Prescriber: Stop Date: RX#: Hour 1 2 3 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 Start Date: Prescriber: Stop Date: RX #: Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 Start Date: Prescriber: Stop Date: RX#: Diagnosis Nurse's Signature initial Nurse's Signature Initial **Documentation Codes** 1. Discontinued Order 2. Refused Allergies 3. Patient out of facility 4. Charted in Error 5. Lock Down Housing Unit: 6. Self Administered Patient ID Number: 7. Medication out of Stock Patient Name: 8. Medication Held 9. No Show

Date of Birth:

12/17/17

10. Other

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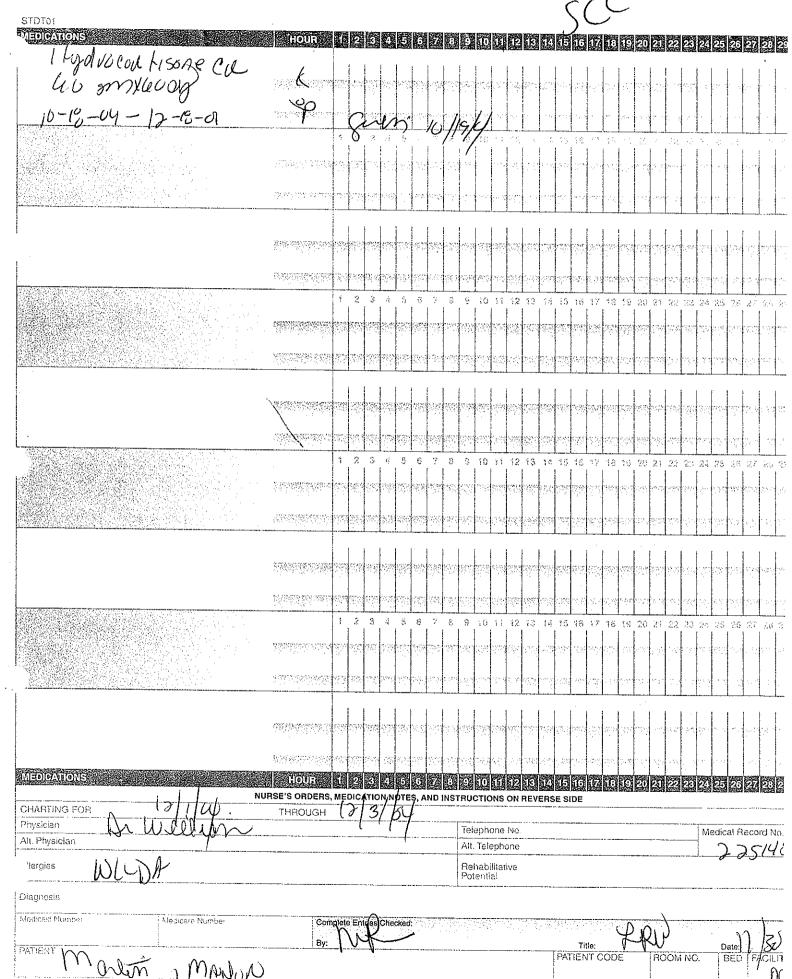
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Martin, Marlos	PATIENT CODE	ROOM NO. BED FACILITY

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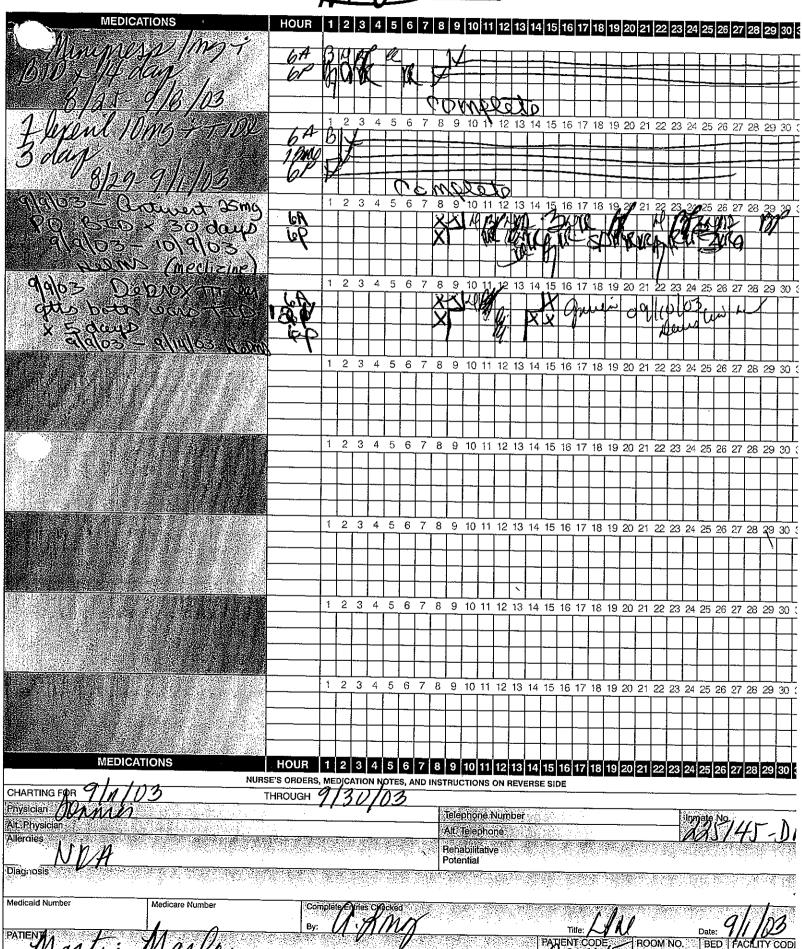
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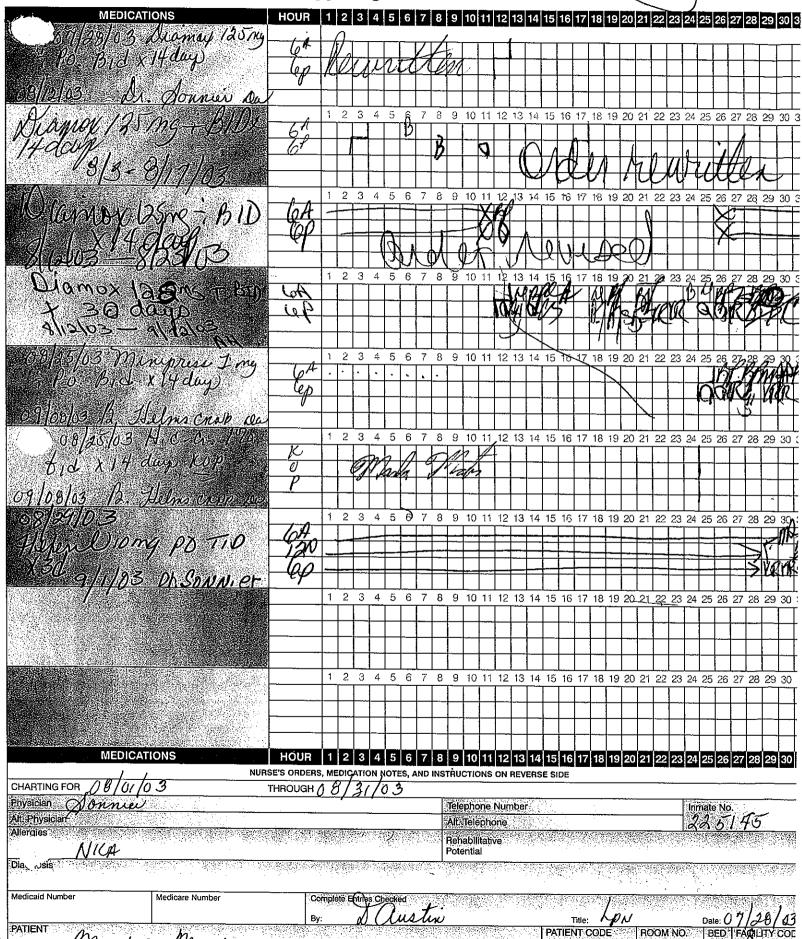


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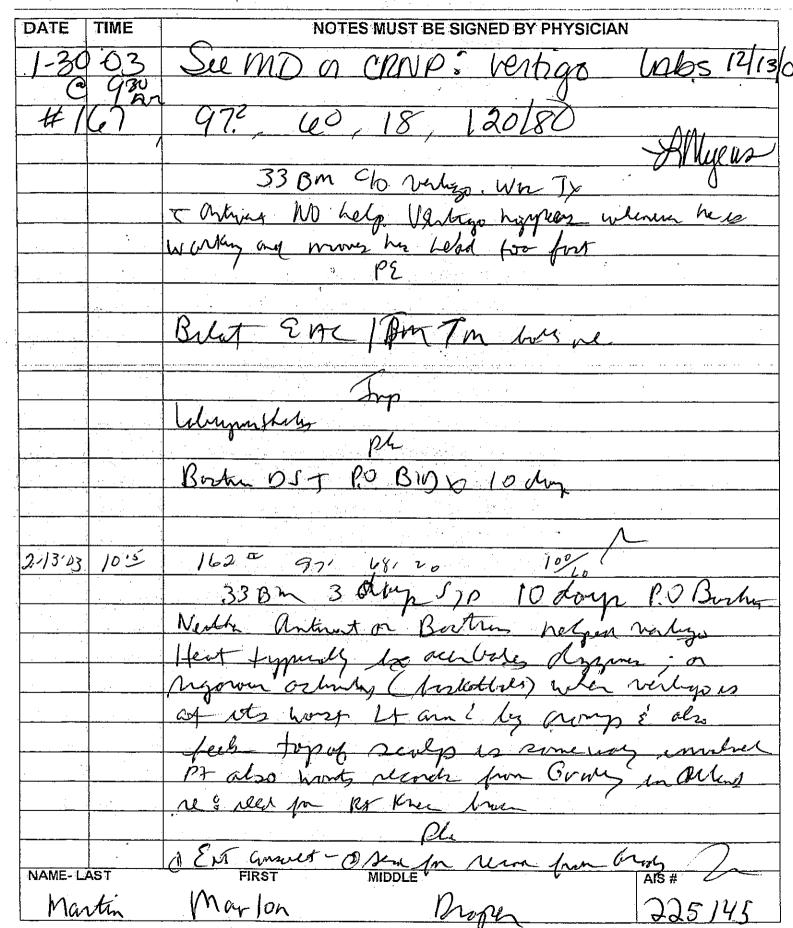






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AIS No. 225/45 Date of Birth 12-17-70 Housing Loc. 2011 Brown
Nature of problem or request 2 then i was got killer they channed my
out mer right ear and the watch hit a merce
causing my balance to be of word than before
my left par still meant clanning 2 when I was at
Killey the Took me know Brack I need one Doct
Sign here for consent to be treated by health staff for the condition described above.
The state of the s
-00 3
DO NOT WRITE BELOW THIS LINE
Subjective: my Balance is off Because the Flustaling las. my V1510Nis Blunch I reed a Knee Brace, they took in wether I fool.
Subjective: my Balances of Security to the took no worth the
Blunde Loled a Kreen nace, they was Mine that Look.
Objective: BP 120/28 P 28 R 20 T 98 WT 172# Whitelobbi material rotal maller inable to 94 Amin. Blan Clan a now AX
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White Coopin millian rotal master. whole is y thing
clenchowAX
Assessment: albrition in Confort Plan: MD to Revoir 1-13-03
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Refer to: PA/ Physician Mental Health Dental
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District (analy) Signature
Protocol used: (specify) 5 and as allowe Signature M 5 CRO W 1/13/6 Bile Time Date
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